DECLARATION OF PERSON RESPONSIBLE FOR A MINOR TO PARTICIPATE IN

Oregon Medical Marijuana Program

MAIL COMPLETED FORM TO: DHS/OMMP, PO BOX 14450, PORTLAND, OREGON 97293-9929

Instructions: Complete all required information in order to comply with the registration requirements of the Oregon Medical Marijuana Act. This form is required in addition to the patient application form if the patient is under 18 years of age.

Please contact the DHS/OMMP if you need this material in an alternative format.	
DECLARATION	
I , do hereby de	clare:
That I am the Custodial Parent or Legal Guardian with responsibility for health care decisions for:	
Applicant's Nan	ne
2. The applicant's attending physician has explained to the applicant and to me the possible risks and benefits of the medical use of marijuana;	
3. I consent to the use of marijuana by the applicant for medical purposes;	
4. I agree to serve as the applicant's designated primary caregiver;	
5. I agree to control the acquisition of marijuana and the dosage and frequency of use by the applicant.	
SIGNATURE OF PERSON WITH PRIMARY CUSTODY:	
APPRESS	T TELEBUIONE NUMBER
ADDRESS:	TELEPHONE NUMBER
CITY, STATE, AND ZIP CODE:	
Subscribed to before me on this	
day of	
Notary Signature	
Seal/Stamp	
Geal/Glamp	
Notary Instructions: If notary is using a raised seal, indicate in which state you are r date your commission expires. Notary signature and seal must appear on this form. Do not at	egistered as a notary and the ttach a separate notary statement.

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